IPDR6702	12/18/2006		**	NORTH CAROLINA		PAGE	: 1	
RUN DATE:	12/18/2006			CHECKWRITE SUMMARY REPORT ECKWRITE DATE: 12/21/2006	1			
				FINANCIAL PAYER: NCDMH				
PROVIDER		HIGH DENIAL	MINDED OF				TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	NUMBER OF DENIALS	DESCRIPTION	TNC DENIALS	TOTAL DENIALS	CLAIMS FINALIZED	CLAIMS PAID
	PROVIDER NAME				DENIALS	DENIALS	FINALIZED	PAID
3404901	SMOKY MOUNTAINM	8599	717	DETAIL NOT COVERED BY COMBINAT				
	H/DD/SAS			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		79	82	THIS SERVICE IS NOT PAYABLE TO	1	928	1497	569
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
		537	30	PROCEDURE IS NOT COVERED FOR T				
		337	30	HIS DATE OF SERVICE				
3404904	WESTERN HIGHLAN	3413	43	PROVIDER TYPE AND SPECIALTY 07				
	DS LME			4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D				
				DENTITY OF VICES ON ON INTERNAL				
		191	34	CLIENT ID NUMBER DOES NOT MATC	0	128	4555	4427
				H PATIENT NAME				
	-	8534	30	SERVICE FACILITY LOCATION IS N				
				OT A VALID IPRS ATTENDING				
				PROVIDER. PLEASE VERIFY THE F				
3404910	PATHWAYS	8599	279	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				
	+	1		BENEFIT PACKAGE.	1			
		8933	230	ADTNC INELIGIBLE TO RECEIVE SE	253	714	3506	2792
				RVICES IN IPRS.				
		11	89	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
3404912	CATAWBA COUNTYM	8599	8	DETAIL NOT COVERED BY COMBINAT				
	ENTAL HEALT			ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
		0	0		0	8	1079	1071
3404913		8518	879	CLAIM DENIED, SUBMITTED BEYOND				
3404313	MECKLENBURG COM ENTAL HEALT	0310	679	FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
		8599	760	DETAIL NOT COVERED BY COMBINAT	60	2857	6130	3273
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
				BENEFII FACKAGE.				
		143	745	CLIENT ID NUMBER NOT ON STATE				
				ELIGIBILITY FILE				
3404916	<del> </del>	21	1890	DUPLICATE OF CLAIM-SYSTEM				
7404210	CROSSROADS BEHA	2.1	1030	DOINICALE OF CHAIM-DISTEM				
	VIORAL HEAL							
		8534	952	SERVICE FACILITY LOCATION IS N	0	4281	11364	7083
				OT A VALID IPRS ATTENDING				
-	1			PROVIDER. PLEASE VERIFY THE F				
	+	8518	705	CLAIM DENIED, SUBMITTED BEYOND				
				FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
2404917		142	120	CITPME ID NUMBED MOT ON CONTROL				
3404917	CENTERPOINT HUM	143	129	CLIENT ID NUMBER NOT ON STATE ELIGIBILITY FILE				
	AN SERVICES							
		8599	116	DETAIL NOT COVERED BY COMBINAT	12	474	4310	3836
				ION OF RECIPIENT, PROVIDER AND				
	-			BENEFIT PACKAGE.				
	+	11	43	CLIENT NOT ELIGIBLE ON SERVICE				
	1			DATE				
3404919	GUILFORD CO MEN	8518	123	CLAIM DENIED, SUBMITTED BEYOND FILING TIMELIMIT. PRIOR				
	TAL HEALTHC			FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE				
	+							
		8599	121	DETAIL NOT COVERED BY COMBINAT	1	297	9731	9434
				ION OF RECIPIENT, PROVIDER AND				
	<del>-</del>			BENEFIT PACKAGE.				
		21	14	DUPLICATE OF CLAIM-SYSTEM				
	1							
		•	1	•	1			

DD OLLT DDD		UTOU DOWN	WINDER OF				TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF	PERCONTENTAL	TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404920	ALAMANCE CASWEL	21	130	DUPLICATE OF CLAIM-SYSTEM				
	L AREA MH D							
	L AKEA MII D							
		8599	60	DETAIL NOT COVERED BY COMBINAT	4	242	1838	1596
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		11	15	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
3404921	onavon progov o	11	1090	CLIENT NOT ELIGIBLE ON SERVICE				
	ORANGE PERSON C HATHAM AREA		1030	DATE				
- '	DAIDAM AREA							
		8505	601	CLAIM DENIED DUE TO INSUFFICIE	0	2394	3779	1385
				NT BUDGET				
		21	390	DUPLICATE OF CLAIM-SYSTEM				
3404922	MILE DIDUM OFFE	21	335	DUPLICATE OF CLAIM-SYSTEM				
	THE DURHAM CENT							
1	ER							
		8599	255	DETAIL NOT COVERED BY COMBINAT	26	969	9717	8748
				ION OF RECIPIENT, PROVIDER AND	20	303	3717	0740
				BENEFIT PACKAGE.				
		8518	132	CLAIM DENIED, SUBMITTED BEYOND				
				FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
3404923	FIVE COUNTY MH	11	105	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
		8536	33	ATTENDING PROVIDER TYPE AND SP				
		8536	33	ECIALTY COMBINATION IS NOT	0	241	3266	3025
				VALID FOR SUBMITTED BILLING PR				
				VADID FOR SUBMITTED BIBBING FR				
		8599	30	DETAIL NOT COVERED BY COMBINAT				
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
3404925	SANDHILLS CENTE	8599	388	DETAIL NOT COVERED BY COMBINAT				
	R FOR MH/DD			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		120	253	CLIENT ID NUMBER MISSING OR IN	102	1276	7463	6187
				VALID. ENTER CID AND SUBMIT				
				AS A NEW CLAIM				
		01	197	DUDITONTE OF CINTM-CVCTPM				
		21	127	DUPLICATE OF CLAIM-SYSTEM				
3404926	acumuna ampp	8599	54	DETAIL NOT COVERED BY COMBINAT				
,	SOUTHEASTERN RE			ION OF RECIPIENT, PROVIDER AND				
-	G MENTAL HL			BENEFIT PACKAGE.				
				1 1 1				
		23	23	SERVICE REQUIRES PRIOR APPROVA	10	148	2131	1983
		1		L	10	140	2131	1903
			1	1				
		3411	15	PROVIDER TYPE AND SPECIALTY 07				
		3411	15	4/113 CANNOT BILL ENHANCED				
		3411	15					
				4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D				
	CUMBERLAND CO M	3411	15	4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D DETAIL NOT COVERED BY COMBINAT				
	CUMBERLAND CO M			4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D  DETAIL NOT COVERED BY COMBINAT  ION OF RECIPIENT, PROVIDER AND				
				4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D DETAIL NOT COVERED BY COMBINAT				
		8599	25	4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D  DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
				4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D  DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  60 RESIDENTIAL LEVEL II TREATM	0	47	980	933
		8599	25	4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D  DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  60 RESIDENTIAL LEVEL II TREATM ENT RECEIVED, PA IS REQUIRED	0	47	980	933
		8599	25	4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D  DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  60 RESIDENTIAL LEVEL II TREATM	0	47	980	933
		8599 8622	25	4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D  DETAIL NOT COVERED BY COMBINAT TON OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  60 RESIDENTIAL LEVEL II TREATM ENT RECEIVED, PA IS REQUIRED FOR ADDITIONAL SERVICE.	0	47	980	933
		8599	25	4/113 CANNOT BILL ENHANCED BENEFIT SERVICES ON OR AFTER D  DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.  60 RESIDENTIAL LEVEL II TREATM ENT RECEIVED, PA IS REQUIRED	0	47	980	933

	1	T		T				
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404930		8599	177	DETAIL NOT COVERED BY COMBINAT				
3404930	JOHNSTON COUNTY MNTL HLTHC	0399	177	ION OF RECIPIENT, PROVIDER AND				
	111111			BENEFIT PACKAGE.				
		0000	120	NO DATE WAYNED ON THE TO D				
		8000	130	NO RATE AVAILABLE ON FILE TO P RICE THIS CLAIM DETAIL	10	528	6007	5479
		10	122	DIAGNOSIS OR SERVICE INVALID F OR CLIENT AGE. VERIFY CID,				
				DIAGNOSIS, PROCEDURE CODE FOR				
3404931	WAKE CO HUM SVC	8518	970	CLAIM DENIED, SUBMITTED BEYOND				
	BILLING OF			FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE				
		8599	535	DETAIL NOT COVERED BY COMBINAT	130	2888	27096	24208
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				
				BENEFIT PACKAGE.				
		21	302	DUPLICATE OF CLAIM-SYSTEM				
3404933	SOUTHEASTERN CT	8599	76	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				
	R FOR MH/DD	+		DENEFIT PACKAGE.				
		11	66	CLIENT NOT ELIGIBLE ON SERVICE	0	234	1792	1558
				DATE				
		1						
		8536	57	ATTENDING PROVIDER TYPE AND SP				
				ECIALTY COMBINATION IS NOT				
		1		VALID FOR SUBMITTED BILLING PR				
3404934	ONSLOW CARTERET	8599	903	DETAIL NOT COVERED BY COMBINAT				
	BEHAV HEAL			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8536	290	ATTENDING PROVIDER TYPE AND SP	1	1750	3003	1253
		0330	230	ECIALTY COMBINATION IS NOT	1	1750	3003	1253
				VALID FOR SUBMITTED BILLING PR				
		8535	216	SERVICE FACILITY LOCATION WAS NOT SUBMITTED ON THIS CLAIM.				
				PLEASE RESUBMIT THE CLAIM WITH				
3404935	WAYNE CO MENTAL	0	0	*** NO DATA TO REPORT ***				
	HEALTH CTR							
		0	0		0	0	0	0
3404936	WILSON-GREENE M	8518	65	CLAIM DENIED, SUBMITTED BEYOND				
	ENTAL HEALT			FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
		0	0			*-		
		-	-		0	65	830	765
3404937	EDGECOMBE NASH	8518	21	CLAIM DENIED, SUBMITTED BEYOND	-	_	-	
	MNTL HLTH C	1		FILING TIMELIMIT. PRIOR FISCAL YEAR DOS (JULY 1 - JUNE				
		21	18	DUPLICATE OF CLAIM-SYSTEM	0	39	1693	1654
3404930		0500	10	DEPAIL NOW COURDED BY COMPTIES				
3404939	NEUSE MENTAL HE ALTH CENTER	8599	18	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND				
	ALLII CENIER	1		BENEFIT PACKAGE.				
		1588	5	CLAIM DENIED. TREATMENT HAS B EEN RENDERED BY	0	28	427	399
				ANOTHER PROVIDER FOR THIS DATE				
		1		-				
		537	2	PROCEDURE IS NOT COVERED FOR T				
		1		HIS DATE OF SERVICE				
		1						
3404941	PITT CO MH/DD/S	8518	18797	CLAIM DENIED, SUBMITTED BEYOND				
	AS CENTER			FILING TIMELIMIT. PRIOR				
		<u> </u>		FISCAL YEAR DOS (JULY 1 - JUNE				
		8534	2155	SERVICE FACILITY LOCATION IS N	0	21596	23394	1798
		1		OT A VALID IPRS ATTENDING	0	21336	23394	1/98
				PROVIDER. PLEASE VERIFY THE F				
		142	204	CLIENT ID NUMBER NOT ON STATE				
		143	204	ELIGIBILITY FILE				
		1						
				•				

	1	1					TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
					-			
3404942	ROANOKE CHOWANH	8599	38	DETAIL NOT COVERED BY COMBINAT				
	UMAN SERVIC			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		0.1	0.5	PURI TOURR OF OVATA OVARRA				
		21	26	DUPLICATE OF CLAIM-SYSTEM	0	101	2863	2762
							<del> </del>	
		11	15	CLIENT NOT ELIGIBLE ON SERVICE				
				DATE				
3404943	ALBEMARLE MENTA	8536	22	ATTENDING PROVIDER TYPE AND SP				
	L HEALTH CE			ECIALTY COMBINATION IS NOT				
				VALID FOR SUBMITTED BILLING PR				
		21	12	DUPLICATE OF CLAIM-SYSTEM	3	51	66	15
		1	1					
		5404	5	SEVERE DUPLICATE: SAME ATTO PR		-		
			-	OV/PCODE/TOS/DOS/MOD				
		+						
3404944	EASTPOINTE HUMA	8534	69	SERVICE FACILITY LOCATION IS N				
	N SERVICES	1		OT A VALID IPRS ATTENDING				
				PROVIDER. PLEASE VERIFY THE F				
		79	1	THIS SERVICE IS NOT PAYABLE TO	0	71	949	878
				YOUR SUBMITTED BILLING				
				PROVIDER TYPE AND SPECIALTY IN				
		24	1	PROCEDURE CODE, PROCEDURE/MODI				
				FIER COMBINATION OR PROCEDURE				
				CODE/TYPE OF SERVICE COMBINATI			-	
3404946	DOOMUTTE A ARRAM	79	425	THIS SERVICE IS NOT PAYABLE TO				
3101310	FOOTHILLS AREAM ENTAL HEALT		123	YOUR SUBMITTED BILLING				
	ENTAL HEADT			PROVIDER TYPE AND SPECIALTY IN				
				1 1				
		8599	71	DETAIL NOT COVERED BY COMBINAT	8	787	5450	4663
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8535	60	SERVICE FACILITY LOCATION WAS				
				NOT SUBMITTED ON THIS CLAIM.				
				PLEASE RESUBMIT THE CLAIM WITH				
2404057		0505	140	OLIVE PRINTED BUD TO THOUSENED BUT				
3404957	TIDELAND MENTAL	8505	148	CLAIM DENIED DUE TO INSUFFICIE NT BUDGET		<del>                                     </del>	<u> </u>	
	HEALTH CTR		1			<del>                                     </del>		
			1			<del>                                     </del>		
		8518	77	CLAIM DENIED, SUBMITTED BEYOND	4	305	2699	2394
		1		FILING TIMELIMIT. PRIOR		303		
				FISCAL YEAR DOS (JULY 1 - JUNE				
		8800	60	FURTHER PROCESSING NECESSARY,				
				PLEASE CHECK FOR CLAIM ON				
				FUTURE RA'S.				
2404970	<u> </u>	3412	58	PROVIDER TYPE AND SPECIALTY 07		<del>                                     </del>	<del>                                     </del>	
3404979	NEW RIVER AREAM	2714	30	4/113 CANNOT BILL ENHANCED		-		
	H/DD/SA PRO			BENEFIT SERVICES ON OR AFTER D		<del> </del>		
		+						
		8599	44	DETAIL NOT COVERED BY COMBINAT	0	171	8333	8162
	1			ION OF RECIPIENT, PROVIDER AND	0	1/1	0333	0102
		1		BENEFIT PACKAGE.				
				1		+	t	
							l	
		120	13	CLIENT ID NUMBER MISSING OR IN				
		120	13	CLIENT ID NUMBER MISSING OR IN VALID. ENTER CID AND SUBMIT AS A NEW CLAIM				